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To: Nursing Home Associations
Nursing Home Administrators
Nursing Home Directors of Nursing
BQC Surveyors

From: Larry Tainter, Director
Bureau of Quality Assurance

Subject: Care Planning

The resident plan of care is the cornerstone of quality care. As such, it should be a funcional tool for care givers to use on a daily basis. Development of a workable care plan requires a concerted effort by facility staff. In response to requests from facility staff we have developed the following Guidelines for Resident Care Planning in Long Term Care Facilities, reflecting current federal and state regulations. The new federal long term care requirements, published in the Federal Register on February 1, 1989, go well beyond current requirements in this area by specifying a minimu data set and uniform resident assessment tool to be used as the basis for all care planning activities, and we will update these guidelines to reflect the new requirements when they go into effect in 1990.

Please share these guidelines with all staff involved in care planning for their use in developing, implementing and updating care plans for your residents.

If you have questions, please contact your district office Field Operations Manager:

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GUIDELINES FOR RESIDENT CARE PLANNING IN LONG TERM CARE FACILITIES

The resident plan of care is the cornerstone of quality care and as such should be a functional tool for all care givers to use on a daily basis. The care plan is an individualized plan developed by all health disciplines and the resident for providing care which will improve the resident's condition or maintain the present optimal condition. Federal regulations require that the administrator or a professional staff person be assigned responsibility for the coordination and monitoring of the resident's overall plans of care (442.304(a),(b)). The care planning process begins with all involved disciplines preparing a history and assessment of the resident's problems, needs and strengths. The information collected is shared during the interdisciplinary care planning conference and provides the basis for the resident's plan of care. Once the care plan is established, evaluation of the effectiveness and updating of the care plan are ongoing parts of the care planning process.

INITIAL CARE PLAN (HSS 132.52(4))

"Upon admission, a plan of care for nursing services shall be prepared and implemented, pending development of the plan of care required by s. HSS 132.60(8)."* This plan of care should incorporate information obtained from the physician's initial plan of care and his or her orders for the immediate care of the resident. It should also include plans for addressing problems identified in the nursing assessment of the resident. This care plan must be followed until development of the resident's care plan.

RESIDENT HISTORY AND ASSESSMENT (HSS 132.52(5))

"Within 72 hours of a resident's admission, a registered nurse shall supervise the preparation of a written history and assessment summarizing the resident's prior health care, patterns of activities of daily living, needs, capabilities and disabilities."

SPECIALTY ASSESSMENTS (HSS 132.52(6))

"Within 2 weeks following admission, each service discipline appropriate to the resident's care, but in all cases dietetics, activities, and social services, shall prepare a history and assessment of the resident's prior health and care in the respective disciplines." When compiling histories and assessments, facility staff should consider the physician's history, physical, diagnoses, orders, rehabilitation potential, laboratory results and pertinent previous records.

DISCHARGE PLANNING (HSS 132.68(4)(a))

"Within two weeks after admission, an evaluation of social needs and potential for discharge shall be completed for each resident;" The potential for discharge must be assessed upon admission and periodically reviewed throughout a resident's stay. "(b) A social services component of the plan of care, including preparation for discharge, if appropriate, shall be developed and included in the plan of care required by s. HSS 132.60(8)(a);"

* All code requirements are underlined and shown in quotations.

RESIDENT CARE PLAN (HSS 132.60(8)(a))

"...within 4 weeks following admission a written care plan shall be developed, based on the resident's history and assessments from all appropriate service disciplines and the physician's evaluation and orders, as required by s. HSS 132.52 ..." The words "a written care plan" are interpreted to mean one overall or total plan of care whcih incorporates major goals and each discipline's (including nursing, dietary, activities, social services and specialized therapies) approaches for meeting those goals.

RESIDENT INVOLVEMENT IN CARE PLANNING

HSS 132.31(1)(n) Care Planning. Be fully informed of one's treatment and care and participate in the planning of that treatment and care.

Federal 42 CFR 405.1121(k) Patients' Rights. See sections (1)-(4) under this standard, with emphasis on paragraph (3), and also the language following paragraph (14), as follows:

> "These patients' rights policies and procedures ensure that, at least, each patient admitted to the facility:
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> (1) Is fully informed, as evidenced by the patient's written acknowledgement, prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct and responsibilities;
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> (2) Is fully informed, prior to or at the time of admission and during stay, of services available in the facility, and of related charges including any charges for services not covered under titles XVIII or XIX of the Social Security Act, or not covered by the facility's basic per diem rate;
>
> (3) Is fully informed, by a physician, of his medical condition unless medically contraindicated (as documented, by a physician, in his medical record), and is afforded the opportunity to participate in the planning of his medical treatment and to refuse to participate in experimental research;
>
> (4) Is transferred or discharged only for medical reasons, or for his welfare or that of other patients, or for nonpayment for his stay (except as prohibited by titles XVIII or XIX of the Social Security Act), and is given reasonable advance notice to ensure orderly transfer or discharge, and such actions are documented in the medical record; ..."

All rights and responsibilities specified in paragraphs (k)(1) through (4) of this section - as they pertain to (i) a patient adjudicated incompetent in accordance with State law, (ii) a patient who is found, by his physician, to be medically incapable of understanding these rights, or (iii) a patient who exhibits a communication barrier - devolve to such patient's guardian, next of kin, sponsoring agency(ies), or representative payee (exception when the facility itself is representative payee) selected pursuant to section 205(j) of the Social Security Act and Subpart Q of 20 CFR Part 404."

In cases where family members are active and the need for guardianship is apparent due to the resident's condition, IF the family is in agreement with medical advice and treatment and it is so documented, the Bureau accepts the family's decisions and does not require that guardianship proceedings be initiated.

Documentation of the family's willingness to assume the role as well as active involvement of the physician with the family should be in the records.

In cases where the individual had no legal arrangement for handling his/her affairs, or where family members are not in agreement or cannot reach agreement, or has no active family involvement, and the need for guardianship is apparent, guardianship should be sought.

The nursing home is required to assess all of their residents for the need of potential guardianship. The assessment should be on an annual basis and should include assessment of the resident's functional status and mental status, and could be included as part of the overall reassessment (need not be a separate assessment).

COMPONENTS OF THE RESIDENT CARE PLAN

The resident care plan should clearly identify and describe the resident's problems and needs and should be written so that care can be given by anyone involved in the resident's care. Routine care given to all residents such as baths, treatments, medication, etc., need not appear on the resident care plan unless these are special approaches for the individual resident. Routine care may be included in the nursing care plan or on an aide assignment sheet. Follow through of the resident care plan is accomplished through documentation on treatment sheets, progress notes, etc.

Needs are the basic requirements of the body and mind which people require for health and survival. An unmet need is a lack of something useful, required or desired. A problem is anything which adversely affects a resident's health, comfort, environment or which causes a concern to the resident, staff or family. Approaches should be concise and specifically related to the identified needs or problems of the resident. All strengths of the resident should be considered when establishing goals and approaches. Strengths may appear as motivation of the resident, family support, coping mechanism, etc.

CARE PLANS FOR THE TERMINALLY ILL

Care planning in relation to terminal illness needs to begin as part of the admission process. At that time, the facility should provide the resident with information about what treatment options are or are not available to them. Included in the treatment options should be well-defined categories of care (in a language understood by residents, active family members and/or guardians) which may include: CPR, no code, supportive care, comfort measures, DNR, invasive procedures, etc. If a facility indicates it offers a treatment option, it must be able to provide that treatment 24 hours a day 7 days a week, 365 days a year. HSS 132.31(1)(d)1.a. states, "An accurate description of the basic services provided by the facility, the rate charged for those services, and the method of payment for them;"

The facility policies should be in writing and include definition of key terms used in the policy such as DNR or no code so there is no misunderstanding to those who read or hear those policies. The resident and designated representative of the resident are the most important members in the decision making process in conjunction with facility staff and the physician. It is important that attending physicians know the facility's policies and procedures in this area.

The resident, family, significant others and/or guardian and physician need to be involved in care planning and decision making. Whenever feasible, the planning needs to be in advance of crises in resident care. Discussion of resident desires and options regarding the conditions for determining usage of life sustaining procedures is most timely when accomplished during initial resident care planning. These decisions should be reviewed on an ongoing basis.

Wis. Stats. 154 regarding the Living Will, the State Medical Society of Wisconsin Guidelines on Terminal Care in Long Term Care Facilities and the facilities' own residents critical care plan are all resources available to the facility for formulating policies and making decisions with reference to treatment options. In addition, please refer to the attached article by Dr. Steven Miles, et al., titled "Nursing Home Policies Addressing the Use or Withdrawal of Life-Sustaining Medical Treatments," which provides an excellent discussion of the issues that need to be addressed in this area plus an extensive bibliography. A recent book by Dr. Miles and Carlos F. Gomez on this subject is also referenced for your information.

The Bureau's position in regard to terminal care planniing and decision-making is that the facility needs to foster an informed decision making process beginning at the time of admission, incorporate it into the care plan, make sure all parties that need to know are aware of the decisions made by the resident or his or her spokesperson(s), and assure that these decisions guide the care provided to the resident.

TEMPORARY PROBLEMS

Temporary problems that are serious or may develop into a serious problem must be formally documented on the plan of care. Problems that are temporary in nature such as a cold, sore throat, bruise, skin scrape, flue, etc., that are not serious need not be included in the resident care plan. These problems must be addressed in progress notes supported by notification of the physician, physician orders, medications given, etc. Facility policy needs to indicate the mechanism by which the temporary problem and plan of care is communicated to staff.

GOALS (HSS 132.60(8)(A)1.)

Goals are measurable outcomes desired for or by the resident. Goals are always written in terms of the resident. A realistic goal must be written for each problem with specific time limits for attainment. Two types of goals used for care planning in long term care facilities are attainment and maintenance.

Attainment goals are used when improvement is a condition can be anticipated. The goals must be measurable in time or in time and degree. Time frames are established for a specific date. Degree is the amount of improvement that is expected within the time frame.

> "Achievement of goals often implies movement or change but can also involve lack of change, slowing of undesired change or living in some form of acceptance of what cannot be modified." (Doris Carnavali, R.N., MN, Nursing Care Planning, Diagnosis and Management, J.B. Lippincott Co., Philadelphia, 1983.)

Maintenance goals are used when a resident's condition indicates that improvement is not likely. Maintenance (or preventive) goals are self-measuring. It is essential that there is careful analysis of the resident's capabilities or responses to treatments prior to establishing maintenance goals. It would not be acceptable to plan to maintain what could be improved. It may be appropriate to establish maintenance goals upon admission if the history and condition of the resident clearly indicates a stable status.

APPROACHES (HSS 132.60(8)(A)2.)

The methods for delivering needed care are the approaches taken to accomplish the goals. Approaches should be written in terms which answer the who, what, where, when and how questions. Since goals may involve one or all disciplines, the approaches must identify the responsible discipline. Approaches must specifically identify the action to be taken, how frequently these actions must occur and by which discipline.

CARE PLANNING CONFERENCE

The resident care plan is a product of a comprehensive team effort, using information from the history and assessments completed by each discipline. Problems, needs and strengths identified from the discipline assessments are used to develop the resident care plan. Each discipline brings their expertise and experience to the conference and their assessment of the resident's status. Together, the team members and resident identify problems or needs, plan the resident's goals, staff approaches and designate the discipline responsible for each approach.

The resident or guardian must be informed of one's treatment and care and be given the oppportunity to participate in the planning of that treatment and care (HSS 132.31(1)(n)), although they may choose not to participate in the planning.

IMPLEMENTATION

"The care plans shall be substantially followed." The care plans must be maintained in the facility and readily available to persons providing care and treatment at all times (HSS 132.45(1)). Each department will be responsible to see that the care plan related to their area of expertise is being followed and accurately documented. Attitudes tpward care plans influence personnel and can create an atmosphere where plans are viewed as essential tools in resident care management. The mere development of the plan for each resident does not ensure it is followed. This can be accomplished through assignment of resident care team members on the basis of their competence and the needs of the residents, and to maximize continuity of care.

EVALUATIONS AND UPDATES (HSS 132.60(8)(b))

"The care of each resident shall be reviewed by each of the services involved in the resident's care and the care plan evaluated and updated as needed." "As needed" is interpreted to mean whenever the resident's condition changes such that a new, revised or modified form of treatment is needed to meet his or her individual needs. The frequency of review will depend on the condition of the resident.

Federal SNF requirements for evaluation and updating the care plan are similar to state rule. "The patient care plan is reviewed, evaluated, and updated as necessary by all professional personnel involved in the care of the patient (405.1124(d))." In an intermediate care facility, the plan of care must be reviewed and revised as needed but the health care plan and activity care plan components of resident care plan must be reviewed at least quarterly (422.341(a),(b) and 422.345(c)(3)).

At the care planning conference the status of the resident and the goals should be reevaluated for the degree of attainment.

Maintenance goals must also be reevaluated at each planning conference. New or additional goals are added in correspondence with any new problems identified. Existing goals and approaches are modified as necessary.

INDIVIDUAL DISCIPLINE CARE PLANS

HSS 132 does not require or prohibit the facility from maintaining individual discipline care plans. Individual disciplines may keep care plans which may be more detailed than the resident care plan.

COMPUTER GENERATED CARE PLANS

As in all other care plans, computer generated care plans must assure individualized problems, needs, goals and approaches are identified. The actual system used should reflect specific differences and idiosyncrasies of the diagnoses identified, problems or needs representing the resident. Approaches or goals should also reflect what is appropriate for the resident. The method of implementation and the evaluation should also reflect individual changes as they occur.

PROBLEM ORIENTED MEDICAL RECORDS (POMR)

A facility may choose to use a POMR charting system as long as all HSS 132 code requirements are met. For example, the facility must complete the initial nursing care plan, the discipline histories and assessments, a resident plan of care, and maintain the multi-disciplinary approach to care planning.

This document was prepared by the Care Planning Workshop of the Bureau of Quality Compliance. In addition to the reference materials that are specific to terminal care planning, we have also included a list of other references recommended by our staff.

LT/SW/jh 7457

cc: -BOALTC
-WMRA Consultants Committee
-Service Employees International Union
-Wis. Coalition for Advocacy
-George F. MacKenzie

References

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"A series of pre-developed patient care plans developed and used by nurses in nursing homes." The Council of Directors of Nursing Service Administration of the Connecticut Association of Health Care Facilities, Inc.

"Care Plans in Long Term Facilities", American Journal of Nursing, November 1980, June W. Gray, Helen Aldred.

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"Maryland Appraisal of Patient Progress - A Patient Care Management System", State of Maryland Department of Health and Mental Hygiene - Division of Licensing and Certification, 1981

"Overall Resident Care Plans", Intermediate Care Facilities Standards and Guidelines, State of Iowa - 1983

"Manual of Nursing Diagnosis", McGraw-Hill, Inc., 1982, Marjory Gordon, R.N., Ph.D., F.A.A.N.